BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
SONIA YACOBIAN, M.D.	Case No: 17-2001-118155
Physician and Surgeon's Certificate #A-52602	
Respondent.	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby accepted and adopted as the Decision and Order by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 17, 2004.

IT IS SO ORDERED April 16, 2004

MEDICAL BOARD OF CALIFORNIA

Ronald Wender, M.D.
Panel B Chair
Division of Medical Quality

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SONIA YACOBIAN 1245 Grandview Ave., No. 3 Glendale, CA 91201 Physician and Surgeon's Certificate No. A 52602 Respondent.	Case No. 17-2001-118155 OAH No. L-2002120594 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Division of Medical Quality, Medical Board of California the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Division for approval and adoption as the final disposition of the Accusation

PARTIES

1. Ron Joseph (Complainant) is the Executive Director of the Medical Board of California. He brought this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Richard D. Marino, Deputy Attorney General.

2. Respondent Sonia Yacobian (Respondent) is represented in this proceeding by attorney Marvin L. Part, whose address is 18034 Ventura Blvd., Encino, CA

91316.

3. On or about November 23, 1993, the Medical Board of California issued Physician and Surgeon's Certificate No. A 52602 to Sonia Yacobian (Respondent). The Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 17-2001-118155 and will expire on August 31, 2005, unless renewed.

JURISDICTION

4. Accusation No. 17-2001-118155 was filed before the Division of Medical Quality (Division) for the Medical Board of California, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 29, 2002. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 17-2001-118155 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 17-2001-118155. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in

Accusation No. 17-2001-118155, if proven at a hearing, constitute cause for imposing discipline upon her Physician and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

10. Respondent agrees that her Physician and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Division's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Division of Medical Quality, Medical Board of California, or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician and Surgeon's Certificate No. A 52602 issued to Respondent Sonia Yacobian is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. PRESCRIBING PRACTICES COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would

have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. ETHICS COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all

expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent failed to complete the clinical training program.

5. MONITORING - PRACTICE/BILLING Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including, but not limited to, any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the

Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice and billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours, and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education

Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

6. SOLO PRACTICE Respondent is prohibited from engaging in the solo practice of medicine.

7. NOTIFICATION Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

9. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

10. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

12. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

13. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility

to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

14. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

15. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation,

respondent's certificate shall be fully restored.

16. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. COST RECOVERY Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $3,500 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent of her obligation to reimburse the Division for its costs.

18. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which are currently set at $2,874.00, but may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its

designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Marvin L. Part. I understand the stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: 1/12/04.

SONIA YACOBIAN
Respondent

I have read and fully discussed with Respondent Sonia Yacobian the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1/12/04.

MARVIN L. PART
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California.

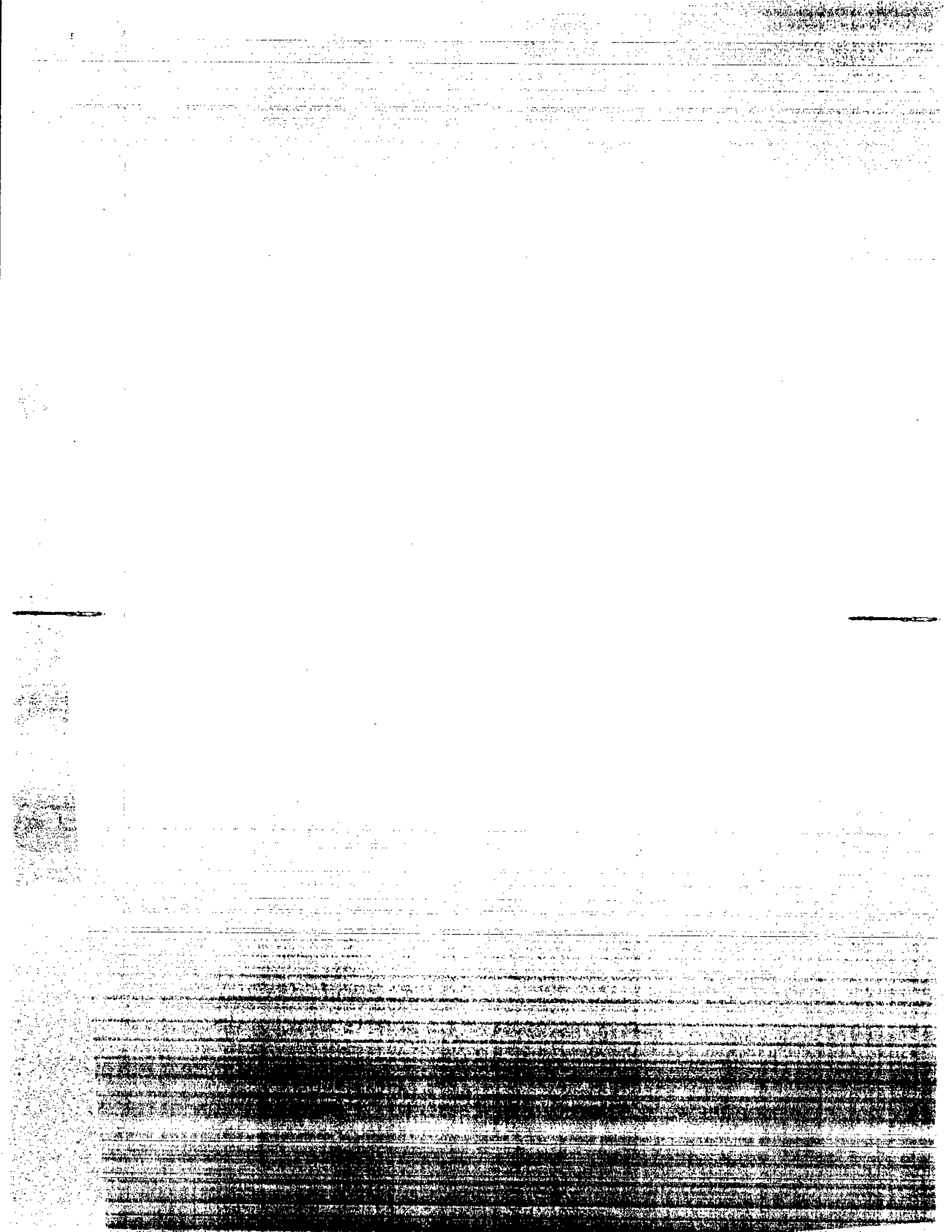
DATED: Jan. 12, 2004.

BILL LOCKYER, Attorney General
of the State of California

RICHARD D. MARINO
Deputy Attorney General

Attorneys for Complainant

DOJ Docket/Matter ID Number: 03573160LA2002ADXXXX
YacobianStipulation.wpd



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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 17-2001-118155
SONIA YACOBIAN 1245 Grandview Ave., No. 3 Glendale, California 91201	**ACCUSATION**
~~Physician~~ and Surgeon's Certificate No. A 52602	
Respondent.	

Complainant alleges:

PARTIES

1. Ron Joseph (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California.

2. On or about November 23, 1993, the Medical Board of California issued Physician and Surgeon's Certificate Number A 52602 to SONIA YACOBIAN (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2003, unless renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California (Division), under the authority of the following sections of the Business and Professions Code (Code) and related laws.

4. Section 2004 of the Code states:

"The Division of Medical Quality shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a medical quality review committee, the division, or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board."

6. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

7. Section 725 of the Code states:

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist. However, pursuant to Section 2241.5, no physician and surgeon in compliance with the California Intractable Pain Treatment Act shall be subject to disciplinary action for lawfully prescribing or administering controlled substances in the course of treatment of a person for intractable pain."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 14124.12 of the Welfare and Institutions Code states, in pertinent

part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

10. Section 125.3 of the Code states:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

"(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

"(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

"(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge where the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

"(e) Where an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licentiate to pay costs.

"(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

"(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licentiate who has failed to pay all of the costs ordered under this section.

"(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licentiate who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

"(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

"(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

"(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about July 28, 2000, Patient T.D. [initials to protect privacy], a female, made her first visit to respondent for care and treatment. A blood pressure of 150/100 was recorded. Respondent diagnosed hypertension, osteoporosis, and briefly noted abnormalities with the abdomen, lungs and musculoskeletal system. Respondent did not delineate, describe or explain these abnormalities.

B. During this initial medical visit, respondent ordered abdominal ultrasound, vasospect [for lower extremity venous function], left forearm bone density, pulmonary function, blood panel and urine tests. The abdominal ultrasound or sonogram report contained handwritten notes but no interpretation or reading from respondent or another physician. The vasospect scan of the right lower extremity showed normal venous flow but no interpretation or reading from respondent or another physician. The bone density study of the left forearm was not accompanied by an interpretation or reading by respondent or another physician. The pulmonary function test results were not accompanied by an interpretation or reading by respondent or another physician. The blood panel results showed elevated ferritin, cholesterol, triglycerides, sedimentation rate, glucose, calcium and Gamma GT, as well as the presence of H. Pylori and Hepatitis A antibodies. The urinalysis was positive for leukocytes with 5 to 7 white blood cells per high-powered field and 2 to 3 red cells per high-powered field. Respondent did not document the abnormalities shown by the blood and urine tests; nor did respondent provide any interpretation or reading of the blood and urine test results in T.D.'s progress notes for this date or for her visit on August 10, 2000.

C. Respondent engaged in an extreme departure from the standard of

practice in the care and treatment of Patient T.D. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering repeat tests or tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(5) By engaging in a pattern of ordering diagnostic tests without medical indication.

SECOND CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

12. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 11 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient T.D. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering repeat tests or tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(5) By engaging in a pattern of ordering diagnostic tests without medical indication.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

13. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 11 are incorporated by reference herein as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Testing)

14. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 11 are incorporated by reference herein as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate Records)

15. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of his care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 11 are incorporated by reference herein as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about July 21, 2000, Patient Z.K. [initials to protect privacy], a female, was seen by respondent for care and treatment. Respondent noted an abnormality with the musculoskeletal system, perhaps osteoarthritis, but provided no delineation, description or explanation of the condition. Respondent ordered pelvic ultrasound, bone density, pulmonary function and vasospect tests without documenting a clear indication for them.

B. The pulmonary function tests showed "moderate obstruction as well as low vital capacity, possibly from a concomitant restrictive defect," but no interpretation or reading from respondent or another physician was documented. The vasospect study showed an abnormal venous flow pattern in both lower extremities, but no interpretation or reading from respondent or another physician was documented. The pelvic ultrasound showed no problems, but no interpretation or reading from respondent or another physician was documented. Respondent provided no written description or explanation regarding the abnormalities found by physical examination.

C. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient Z.K. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to address by written interpretation or reading

the abnormalities shown by test result.

(4) By engaging in a pattern of ordering diagnostic tests without medical indication.

SEVENTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

17. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 16 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient Z.K. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to address by written interpretation or reading the abnormalities shown by test result.

(4) By engaging in a pattern of ordering diagnostic tests without medical indication.

EIGHTH CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered

paragraph 16 are incorporated by reference herein as if fully set forth.

NINTH CAUSE FOR DISCIPLINE

(Excessive Testing)

19. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 16 are incorporated by reference herein as if fully set forth.

TENTH CAUSE FOR DISCIPLINE

(Inadequate Records)

20. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 16 are incorporated by reference herein as if fully set forth.

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about March 16, 2000, Patient S.S.-M. [initials to protect privacy], a male, made his initial visit to respondent for care and treatment. A blood pressure of 160/100 and alcohol use were noted. Abnormalities with the heart and lungs were briefly cited, but without delineation, description or explanation. Respondent diagnosed hypertension, chronic obstructive pulmonary disease, CHF and low back pain. The treatment plan included provision of a support belt and continuation of S.S.-M.'s medications (i.e., Klonopin, Motrin, Lotensin, Lasix and aspirin).

B. On or about August 21, 2000, S.S.-M. made his next and last visit to respondent for care and treatment. The prior problems were noted. A blood pressure of 180/110 was recorded. Abnormalities with the "breasts" and musculoskeletal system were briefly noted, but without delineation, description or explanation. Respondent ordered a blood panel and pulmonary function tests. The blood panel revealed elevated cholesterol, triglycerides, sedimentation rate, amylase and Gamma GT, as well as the presence of H. Pylori and Hepatitis B antibodies. Respondent did not provide an interpretation or reading of the blood and pulmonary function test results. Respondent did not document whether S.S.-M. was notified about the abnormalities indicated by the blood test results.

C. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient S.S.-M. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering pulmonary function tests without adequately documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by written interpretation or reading the result(s) of the pulmonary function tests.

(5) By failing to adjust or alter treatment once the patient's rise in blood pressure (i.e., 160/100 to 180/110) was recorded; and/or failing to document same.

TWELFTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

22. Respondent is subject to disciplinary action under section 2234,

subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 21 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient S.S.-M. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering pulmonary function tests without adequately documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by written interpretation or reading the result(s) of the pulmonary function tests.

(5) By failing to adjust or alter treatment once the patient's rise in blood pressure (i.e., 160/100 to 180/110) was recorded; and/or failing to document same.

THIRTEENTH CAUSE FOR DISCIPLINE

(Incompetence)

23. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 21 are incorporated by reference herein as if fully set forth.

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FOURTEENTH CAUSE FOR DISCIPLINE

(Excessive Testing)

24. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 21 are incorporated by reference herein as if fully set forth.

FIFTEENTH CAUSE FOR DISCIPLINE

(Inadequate Records)

25. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 21 are incorporated by reference herein as if fully set forth.

SIXTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

26. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about August 7, 2006, Patient M.G. [initials to protect privacy], a female, presented to respondent with a complaint of hot flashes. Respondent briefly noted an abdominal abnormality by physical examination, but did not provide a delineation, description or explanation of the condition. Respondent diagnosed irregular menstrual cycle and hot flashes. Respondent ordered vasospect, bone density, pulmonary function, pelvic ultrasound and blood panel tests.

B. The pelvic ultrasound test was normal, but respondent provided no interpretation or reading of the result. The bone density study showed a medium risk, but

respondent provided no interpretation or reading of the result. The vasospect study showed an abnormal venous pattern in both lower extremities, possibly "venous insufficiency," but respondent provided no interpretation or reading of this result. The blood panel revealed elevated sedimentation rate and TSH, but respondent provided no interpretation or reading of these results. Respondent did not document a plan for treatment or further evaluation of these test indicated conditions. The pulmonary function tests indicated borderline obstruction and severe obstruction, but respondent provided no interpretation or reading of these results. Respondent diagnosed hypothyroidism and osteoarthritis, and prescribed medication.

C. On or about August 17, 2000, M.G. returned to see respondent for care and treatment. It is unclear from respondent's record that the abnormalities shown by testing earlier this month were explained to M.G. Respondent noted abnormalities with the lungs upon physical examination, but did not delineate, describe or explain them.

D. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient M.G. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to adequately document how the abnormalities found through diagnostic testing would be addressed (i.e., plan of treatment).

(4) By failing to adequately document a medical necessity for ordering pulmonary function, vasospect, bone density and pelvic imaging studies.

(5) By failing to address by written interpretation or reading the findings shown by test result.

(6) By engaging in a pattern of ordering diagnostic tests without medical indication.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

27. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 26 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient M.G. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to adequately document how the abnormalities found through diagnostic testing would be addressed (i.e., plan of treatment).

(4) By failing to adequately document a medical necessity for ordering pulmonary function, vasospect, bone density and pelvic imaging studies.

(5) By failing to address by written interpretation or reading the findings shown by test result.

(6) By engaging in a pattern of ordering diagnostic tests without medical necessity.

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EIGHTEENTH CAUSE FOR DISCIPLINE

(Incompetence)

28. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 26 are incorporated by reference herein as if fully set forth.

NINETEENTH CAUSE FOR DISCIPLINE

(Excessive Testing)

29. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 26 are incorporated by reference herein as if fully set forth.

TWENTIETH CAUSE FOR DISCIPLINE

(Inadequate Records)

30. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 26 are incorporated by reference herein as if fully set forth.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

31. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about August 8, 2000, Patient S.Z. [initials to protect

privacy], a female, presented to respondent with a complaint of pain and swelling in the area of the right ovary, which was confirmed by physical examination. Respondent ordered a pelvic ultrasound, which revealed a cystic mass on the left ovary, but was otherwise normal. Respondent did not document an interpretation or reading of this pelvic sonogram result.

B. On or about September 8, 2000, S.Z. returned to respondent. Respondent briefly noted abdominal, rectal and vaginal abnormalities, but did not delineate, describe or explain them, with the exception of noting a vaginal discharge. Respondent diagnosed recurrent vaginitis and pelvic inflammatory disease.

C. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient S.Z. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to evaluate further the reported right ovarian pain and swelling (i.e., no pelvic CT scan) to determine the discrepancy between the ultrasound and physical findings; and/or failing to document same.

(4) By failing to refer the patient to a gynecologist for treatment of the left ovarian cyst detected by ultrasound testing; and/or failing to document same.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

32. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The

circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 31 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient S.Z. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to evaluate further the reported right ovarian pain and swelling (i.e., no pelvic CT scan) to determine the discrepancy between the ultrasound and physical findings; and/or failing to document same.

(4) By failing to refer the patient to a gynecologist for treatment of the left ovarian cyst detected by ultrasound testing; and/or failing to document same.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Incompetence)

33. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 31 are incorporated by reference herein as if fully set forth.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Inadequate Records)

34. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and

treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 31 are incorporated by reference herein as if fully set forth.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

35. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about June 20, 1996, Patient A.G. [initials to protect privacy], a female, made her first visit to respondent for care and treatment. She complained of hot flashes, vaginal discharge and low back pain. Respondent diagnosed vaginitis, low back pain and hypothyroidism. A mammogram, blood and urine tests were ordered. The tests showed the following: elevated cholesterol (i.e., 236) and triglycerides (i.e., 399), abnormal LDH and ferritin, abnormal serum protein by electrophoresis, and H. Pylori and Hepatitis A antibodies.

B. On or about November 21, 1996, repeat testing of A.G. showed H. Pylori antibodies, urinary tract infection, elevated sedimentation rate, and abnormal serum protein by electrophoresis.

C. Sometime in December 1996, respondent noted A.G.'s complaint of abdominal pain and diagnosed colitis. H. Pylori and Hepatitis A antibodies were shown by blood test. Protein electrophoresis was normal.

D. On or about January 23, 1997, Dr. Abdulian, a gastroenterologist, performed an upper endoscopy which showed esophagitis, severe gastritis, peptic ulcer disease and H. Pylori infection. Dr. Abdulian recommended Prevacid 30 mg. x2, Clyndamycin 500 mg. x2, and Metronidazole 500 mg. x2. An ultrasound was ordered, but no final report from the physician is in respondent's record on A.G., except for a handwritten note from the technologist indicating hepatomegaly. Respondent did not

note an adjustment in A.G.'s medications, to reflect Dr. Abdulian's recommended treatment; nor did respondent document an assessment of the treatment recommended by Dr. Abdulian. Respondent prescribed Noroxin for urinary tract infection, but no urinalysis or urine culture findings were documented to support the prescription. Respondent did not document a treatment plan to address the H. Pylori infection or peptic ulcer disease.

E. On or about February 20, 1997, A.G. returned to respondent for care and treatment. Respondent again diagnosed urinary tract infection and prescribed Noroxin, but no urinalysis or urine culture findings were documented to support the diagnosis or prescription.

F. On or about March 18, 1997, A.G. returned to respondent for examination. Respondent noted an elevated sedimentation rate. Urinary tract infection was diagnosed and Noroxin prescribed, but no urinalysis or urine culture findings were documented to support the diagnosis and prescription. This pattern of unsupported diagnosis and prescription for urinary tract infection was repeated during A.G.'s subsequent visits to respondent in April and May 1997.

G. On or about June 19, 1997, A.G. was examined by respondent for a complaint of vaginal discharge. A Pap smear was normal. Repeat blood testing showed an abnormal sedimentation rate and H. Pylori antibodies. Noroxin was prescribed.

H. On or about July 24, 1997, A.G. was seen by respondent. Respondent did not document an interpretation or reading of the abnormal test results from March 18 and June 19, 1997, nor that an explanation of these results had been provided to A.G.

I. On or about December 11, 1997, A.G. was seen by respondent, who ordered repeat blood and urine tests. This testing showed an abnormal sedimentation rate and H. Pylori antibodies. A urine culture was negative.

J. On or about May 12, 1998, A.G. was examined by respondent. A blood pressure of 140/90 was recorded. Severe pulmonary obstruction by test result was

noted.

K. On or about July 8, 1998, A.G. was examined by respondent, who noted a cardiovascular abnormality, but without delineating, describing or explaining it.

L. On or about August 27, 1998, A.G. was examined by respondent. A blood pressure of 140/90 was noted. Respondent briefly noted neck, thyroid and musculoskeletal problems, but did not delineate, describe or explain them. Blood, urine, bone density and Pap smear tests were ordered. These tests were negative, but respondent did not provide any interpretation or reading of the results.

M. On or about November 18, 1998, A.G. was examined by respondent. Blood and urine tests were ordered. The results were negative, except for a finding of H. Pylori antibodies.

N. On or about January 19, 1999, A.G. was examined by respondent. A blood pressure of 140/90 was recorded. Respondent briefly noted abdominal and musculoskeletal abnormalities, but did not delineate, describe or explain them.

O. On or about August 4, 1999, respondent ordered more blood tests. The results thereof included elevated uric acid, white blood cell count and sedimentation rate, as well as H. Pylori and Hepatitis A antibodies.

P. On or about August 6, 1999, blood tests ordered by respondent for thyroid and collagen vascular diseases were negative.

Q. On or about August 17, 1999, urinalysis and urine culture results were positive for nitrates and infection. Noroxin was prescribed.

R. On or about March 27, 2000, A.G. was examined by respondent. A pre-visit blood test showed an elevated sedimentation rate, but urinalysis and urine culture results were negative. Respondent briefly noted abdominal and musculoskeletal abnormalities, but did not delineate, describe or explain them.

S. On or about July 27, 2000, respondent briefly noted abdominal and rectal abnormalities by physical examination, but did not delineate, describe or explain them. Blood tests were ordered. Medication was continued.

T. On or about August 1, 2000, a letter was sent to respondent from Dr. Pidoux, a cardiologist, advising an increase in A.G.'s dose of Lipitor to 40 mg. and Lotensin to 40 mg.

U. On or about August 25, 2000, respondent examined A.G., and briefly noted abdominal pain, colitis, urinary tract infection and musculoskeletal problems. None of these problems were delineated, described or explained by respondent. No evaluative steps in support of the colitis diagnosis were documented.

V. On or about October 27, 2000, respondent examined A.G., and noted hot flashes, hypertension, abnormal rectum, elevated sedimentation rate and H. Pylori antibodies. Respondent's written reference to a rectal abnormality was not accompanied by a delineation, description or explanation.

W. On or about October 31, 2000, respondent examined A.G. An abdominal abnormality was briefly noted, but without delineation, description or explanation. A nerve conduction test showed median nerve deficit.

X. On or about November 28, 2000, respondent examined A.G. Lipitor 20 mg. was continued.

Y. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient A.G. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By continuing to treat urinary tract infection during the period January 23 through May 1997, despite negative cultures (i.e., less than 100,000 colonies of bacteria) and negative urinalysis findings (i.e., lack of bacteria, white and red blood cells).

(4) By failing to follow the treatment recommendations of a cardiologist (i.e., Dr. Pidoux) and a gastroenterologist (i.e., Dr. Abdulian); and/or failing to document the reasons for ignoring their recommendations.

(5) By ordering tests by panel and repeat tests showing the same abnormalities without documenting any reason(s) for doing so.

(6) By failing to formulate a treatment plan to address the recurrent findings of elevated sedimentation rate and serum protein electrophoresis; and/or failing to document same.

(7) By failing to address by written interpretation or reading the abnormalities shown by test result (i.e., vasospect, abdominal ultrasound, pulmonary function, bone density).

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

36. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 35 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient A.G. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By continuing to treat urinary tract infection during the period January 23 through May 1997, despite negative cultures (i.e., less than 100,000 colonies of bacteria) and negative urinalysis findings (i.e., lack of bacteria, white and red blood cells).

(4) By failing to follow the treatment recommendations of a cardiologist (i.e., Dr. Pidoux) and a gastroenterologist (i.e., Dr. Abdulian); and/or failing to document the reasons for ignoring said recommendations.

(5) By ordering tests by panel and repeated tests showing the same abnormalities without documenting any reason(s) for doing so.

(6) By failing to formulate a treatment plan to address the recurrent findings of elevated sedimentation rate and serum protein electrophoresis; and/or failing to document same.

(7) By failing to address by written interpretation or reading the abnormalities shown by test result (i.e., vasospect, abdominal ultrasound, pulmonary function, bone density).

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

37. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts. circumstances and opinions stated at above numbered paragraph 35 are incorporated by reference herein as if fully set forth.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Excessive Testing)

38. Respondent is subject to disciplinary action under section 725 of the Code,

in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 35 are incorporated by reference herein as if fully set forth.

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Inadequate Records)

39. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 35 are incorporated by reference herein as if fully set forth.

THIRTIETH CAUSE FOR DISCIPLINE

(Gross Negligence)

40. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about March 24, 1995, Patient G.S. [initials to protect privacy], a female, made her initial visit to respondent for care and treatment. G.S. presented with a history of diabetes, hypertension and hypothyroidism, and reliance on Premarin, Mevacor, Dia Beta, Tenormin and Synthroid. No major physical findings were noted by respondent.

B. Sometime in December 1995, respondent ordered blood and urine tests for G.S.

C. On or about January 18, 1996, G.S. was examined by respondent. The test results from December 1995 revealed the following problems: elevated blood sugar, H. Pylori antibodies, elevated sedimentation rate, and mildly abnormal serum protein electrophoresis. Respondent did not document an interpretation or reading of

these results; nor that an explanation of the results had been provided to G.S.

D. Sometime in April 1996, respondent ordered further blood tests for G.S.

E. On or about April 30, 1996, respondent examined G.S. The test results from earlier this month revealed the following: elevated blood sugar, elevated sedimentation rate, H. Pylori and hepatitis antibodies. Respondent did not provide an interpretation or reading of the test results. Respondent repeated the diagnoses of diabetes and hypothyroidism, and prescribed medication.

F. On or about February 12, 1998, respondent examined G.S. and changed her diabetes medication to Glipizide 20 mg. x2 and Glucophage 500 mg. x2. Respondent did not document the reason(s) for changing G.S.'s diabetes medication.

G. On or about May 28, 1998, G.S. presented to respondent with complaints of headache and itching at the ears. A blood pressure of 150/100 was noted. A treadmill test and myocardial perfusion scan were ordered, with the result that a deficit consistent with a small infarct was found. The sedimentation rate remained elevated. Respondent did not document an interpretation or reading of these test results. Respondent briefly noted abnormalities with the cardiovascular system, lungs, ears and vagina, but did not delineate, describe or explain them.

H. On or about June 8, 1998, respondent ordered a cardiology consultation for G.S. Abdominal, cardiovascular and musculoskeletal abnormalities were briefly noted, but were not delineated, described or explained.

I. On or about June 16, 1998, a stress echocardiogram indicated a possible ischemic response.

J. On or about June 19, 1998, respondent examined G.S. The abnormal cardiac test result from June 16, 1998 was not interpreted or read by respondent; nor did respondent document that G.S. was advised of this abnormal test result.

K. On or about July 16, 1998, respondent examined G.S. Her diabetes

medication was noted as Glucophage 500 mg. x2 and Glucotrol 20 mg. x2. Respondent noted the performance of a bone density scan, but its result was not documented.

L. On or about August 17, 1998, respondent took a random blood sugar from G.S. The glucose level was noted as 159 mg/dl.

M. On or about August 22, 1998, a CT scan of G.S.'s head was normal.

N. On or about September 18, 1998, respondent examined G.S. and briefly noted abnormalities, none of which was delineated, described or explained. This pattern of inadequate documentation was repeated during G.S.'s visits to respondent on October 27 and December 2, 1998.

O. From January 12 to February 11, 1999, respondent had G.S. undergo physical therapy sessions for low back pain. Respondent did not document the results of this therapy.

P. On or about March 22, 1999, respondent examined G.S. A blood test showed an elevated glucose level. A hepatitis panel was positive. Respondent did not provide an interpretation or reading of these abnormal laboratory test results.

Q. On or about August 9, 1999, respondent examined and tested G.S. Her blood sugar was elevated, but the hemoglobin AIC showed a fairly good control of the glucose. The sedimentation rate remained elevated.

R. On or about March 23, 2000, respondent examined and tested G.S. Blood sugar and sedimentation rate remained elevated. Hepatitis A and B antibodies were found. Mild anemia was detected.

S. On or about October 16, 2000, G.S. underwent laboratory tests as a follow-up to her discharge from the hospital where she had been treated for a cardiovascular problem. These tests showed an absence of hepatitis. Blood sugar and sedimentation rate remained elevated. The hemoglobin AIC showed poor control of the diabetes, a significant change.

T Sometime in January 2001, respondent increased G.S.'s dose of

Glucophage to 850 mg. x2, and this dosage was continued into May 2001. The hemoglobin AIC continued to show poor control of the diabetes. G.S.'s blood sugar in May 2001 was recorded as 358 mg/dl, a markedly elevated level. Respondent did not document that G.S. was notified of this result and advised to return for immediate intervention. In fact when G.S. was seen one week later, respondent did not test for blood sugar, document the giving of instructions to G.S. about controlling the elevated blood sugar, or note a plan of treatment for the worsening condition.

U. On or about June 3, 2001, G.S. was hospitalized for elevated blood sugar. Respondent noted that G.S.'s blood sugar level had remained within the 400 to 500 mg/dl range for two to three weeks leading up to her hospital admission.

V. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient G.S. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering repeat tests or tests by panel without documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(5) By failing to formulate a plan to address the elevated blood sugar found in May 2001; and/or failing to document same.

(6) By failing to re-test blood sugar within one week of the first markedly elevated finding; and/or failing to document same.

(7) By failing to adequately treat the highly elevated,

potentially life threatening blood sugar (i.e., 400 to 500 mg/dl range) existing for several weeks prior to the patient's hospitalization for same in June 2001; and/or failing to document same.

THIRTY-FIRST CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

41. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 40 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient G.S. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering repeat tests and tests by panel without documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(5) By failing to formulate a plan to address the elevated blood sugar found in May 2001; and/or failing to document same.

(6) By failing to re-test blood sugar within one week of the first markedly elevated finding; and/or failing to document

same.

(7) By failing to treat the highly elevated, potentially life threatening blood sugar (i.e., 400 to 500 mg/dl) existing for several weeks prior to the patient's hospitalization for same in June 2001; and/or failing to document same.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Incompetence)

42. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 40 are incorporated by reference herein as if fully set forth.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Excessive Testing)

43. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 40 are incorporated by reference herein as if fully set forth.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Inadequate Records)

44. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 40 are incorporated by reference herein as if fully set forth.

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THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

45. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about March 6, 1999, Patient N.A. [initials to protect privacy], a female, at respondent's direction, took a Pap smear test which contained no endocervical cells. Respondent did not document an order for a repeat Pap smear test, in light of the flawed test result.

B. On or about March 12, 1999, N.A. visited respondent with a complaint of abdominal pain. Respondent briefly noted problems with N.A.'s eyes, thyroid, neck, lungs and bones, but did not delineate, define or explain these problems. Respondent did not document an assessment or plan of treatment.

C. On or about March 25, 1999, respondent ordered a low pelvic ultrasound for N.A., but did not document any reason(s) therefor.

D. On or about March 29, 1999, respondent ordered a mammogram for N.A., which showed an asymmetric density in the right breast. Respondent did not document any follow-up treatment or plan for such.

E. On or about March 30, 1999, respondent ordered a breast ultrasound for N.A., but did not document any reason(s) therefor.

F. On or about June 10, 1999, N.A. visited respondent. Laboratory tests revealed anemia, hyperlipidemia, hyperuricemia, hyperkalemia, elevated creatinine and hepatitis antibodies. Respondent briefly cited abnormalities but did not delineate, describe or explain them. Respondent did not document an assessment or treatment plan. The need, if any, for repeat testing or further evaluation was not documented.

G. On or about June 24, 1999, N.A. visited respondent, who again briefly noted abnormalities without delineating, describing or explaining them.

H. On or about August 27, 1999, N.A. visited respondent, who again briefly noted abnormalities without delineating, describing or explaining them.

I. On or about September 7, 1999, respondent prescribed medical supplies for N.A. without documenting the reason(s) for said prescription.

J. On or about October 19, 1999, respondent ordered a lumbar corsette for N.A. without documenting a medical indication for the prescription.

K. On or about January 20, 2000, respondent had N.A. undergo a Pap smear test, which contained no endocervical cells. Respondent did not document an order for repeat Pap smear testing. Respondent also failed to document an interpretation or reading of the abnormal test results reported near the date of this visit (i.e., anemia, hyperuricemia, abnormal kidney function).

L. On or about August 7, 2000, respondent briefly noted abdominal abnormalities without delineating, describing or explaining them. Respondent ordered bone density, pulmonary function and ~~in~~ospect tests without documenting a medical indication for them. The pulmonary function tests showed severe obstruction. A blood test showed anemia, hyperuricemia, elevated sedimentation rate, and abnormal kidney function. Respondent did not document an interpretation or reading of these test results; nor document an assessment or treatment plan. A pelvic ultrasound test was performed, but respondent did not document an interpretation or reading of its ~~result~~(s).

M. From December 2000 through July 23, 2001, respondent created multiple progress notes for N.A., each of which consisted of one word findings per organ system and assessments confined to diagnoses, but without notation to treatment plans.

N. On or about February 8, 2001, a laboratory test order sheet, used by respondent in the care of N.A., showed that every test available had been ordered, including a PSA for prostate cancer, which is applicable only to males. On this sheet, respondent noted anemia, coronary artery disease, hepatitis, hyperlipidemia, liver disease, osteoarthritis, pancreatic disorder, hypothyroidism, osteoporosis, rheumatoid arthritis, systemic lupus erythematosus, venereal disease and gastritis as diagnoses for N.A.,

though respondent's records for N.A. substantiated only a few of these conditions.

O. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient N.A. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering a PSA test to detect prostate cancer for a female patient.

(4) By ordering repeat tests or tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By indicating multiple diagnoses on a preprinted test order form without documented substantiation for said diagnoses.

(6) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(7) By engaging in a pattern of ordering diagnostic tests without medical indication.

THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

46. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 45 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of

practice in the care and treatment of Patient N.A. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering a PSA test to detect prostate cancer for a female patient.

(4) By ordering repeat tests or tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By indicating multiple diagnoses on a preprinted test order form without documented substantiation for said diagnoses.

(6) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(7) By engaging in a pattern of ordering diagnostic tests without medical indication.

THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

47. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 45 are incorporated by reference herein as if fully set forth.

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THIRTY-EIGHTH CAUSE FOR DISCIPLINE

(Excessive Testing)

48. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 45 are incorporated by reference herein as if fully set forth.

THIRTY-NINTH CAUSE FOR DISCIPLINE

(Inadequate Records)

49. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 45 are incorporated by reference herein as if fully set forth.

FORTIETH CAUSE FOR DISCIPLINE

(Gross Negligence)

50. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. Sometime prior to June 12, 2000, Patient E.A. [initials to protect privacy], a female, made her initial visit to respondent for care and treatment. Respondent briefly noted heart and musculoskeletal abnormalities without delineating, describing or explaining them.

B. From June 12 to July 31, 2000, respondent received reports of ten physical therapy sessions for E.A. to address a lower back problem. Respondent did not delineate, describe or explain the type of back problem to be addressed by the physical therapy; nor did respondent document whether the physical therapy had resulted in any

change of symptoms.

C. On or about August 29, 2000, E.A. presented for follow-up treatment of her chronic obstructive pulmonary disease, but respondent did not document whether therapy was provided on this date.

D. On or about September 26, 2000, respondent noted the presence of a peptic ulcer and urinary tract infection. A musculoskeletal abnormality was briefly cited but without delineation, description or explanation thereof.

E. On or about March 1, 2001, E.A. presented to respondent for examination. Respondent noted hypertension and urinary tract infection. A written treatment plan was illegible.

F. On or about March 29, 2001, a laboratory test order sheet, used by respondent in the care of E.A., showed that every test available had been ordered, including a PSA for prostate cancer, which is applicable only to males. On this sheet, respondent noted anemia, coronary artery disease, hepatitis, hyperlipidemia, liver disease, osteoarthritis, pancreatic disorder, hypothyroidism, myocardial infarction, osteoporosis, rheumatoid arthritis, systemic lupus erythematosus, venereal disease and gastritis as diagnoses for E.A., through respondent's records for E.A. substantiated only a few of these conditions.

G. On or about June 14, 2001, E.A. returned to respondent. No interpretation of the test results from March 29, 2001 is documented in E.A.'s chart. These tests indicated elevated choiesterol, the need for a Pap smear, and the need for an ultrasound verification of a probable lymph node detected by mammogram.

H. On or about July 31 and August 7, 2001, E.A. visited respondent for treatment. Respondent did not document a plan of treatment to address the abnormal test results from March 29, 2001.

I. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient E.A. as follows:

(1) By failing to delineate, describe and explain the types of

abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities briefly noted from physical examination; and/or failing to document same.

(3) By ordering a PSA test to detect prostate cancer for a female patient.

(4) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By indicating multiple diagnoses on a preprinted test order form without documented substantiation for said diagnoses.

(6) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(7) By engaging in a pattern of ordering diagnostic tests without medical indication.

(8) By failing to adequately document any reason(s) for ordering physical therapy, and failing to document the results thereof.

FORTY-FIRST CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

51. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 50 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient E.A. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities briefly noted from physical examination; and/or failing to document same.

(3) By ordering a PSA test to detect prostate cancer for a female patient.

(4) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By indicating multiple diagnoses on a preprinted test order form without documented substantiation for said diagnoses.

(6) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(7) By engaging in a pattern of ordering diagnostic tests without medical indication.

(8) By failing to adequately document any reason(s) for ordering physical therapy, and failing to document the results thereof.

FORTY-SECOND CAUSE FOR DISCIPLINE

(Incompetence)

52. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 50 are incorporated by reference herein as if fully set forth.

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FORTY-THIRD CAUSE FOR DISCIPLINE

(Excessive Testing)

53. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 50 are incorporated by reference herein as if fully set forth.

FORTY-FOURTH CAUSE FOR DISCIPLINE

(Inadequate Records)

54. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 50 are incorporated by reference herein as if fully set forth.

FORTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

55. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about July 29, 1998, Patient S.B. [initials to protect privacy], a female, presented to respondent for care and treatment. Respondent briefly noted ear, nose, throat, thyroid, neck and lung problems without delineation, description or explanation thereof.

B. On or about February 16, 1999, laboratory testing of S.B. ordered by respondent showed elevated cholesterol, triglycerides, Gamma GT, and CPK, as well as H. Pylori and hepatitis antibodies. Respondent did not document an interpretation or reading of these test results.

C. On or about February 18, 1999, a Pap smear of S.B. ordered by respondent did not contain an endocervical cell component. Respondent did not document an order for a repeat Pap smear.

D. On or about February 19, 1999, further laboratory testing ordered by respondent showed an elevated sedimentation rate, Gamma GT and cholesterol. Respondent did not document an interpretation or reading of these test results.

E. On or about March 15, 1999, a mammogram performed on S.B. showed soft tissue density in the upper, outer quadrant of both breasts. A six (6) month follow-up was recommended by the radiologist. Respondent did not order a follow-up mammogram for S.B. until one year later, on March 20, 2000, which showed two lesions in the upper, outer right breast and one lesion in the upper, outer left breast.

F. On or about July 9, 1999, respondent ordered multiple laboratory tests for S.B. These tests showed elevated cholesterol and triglycerides. Respondent did not document an interpretation or reading of these test results.

G. On or about July 16, 1999, a complete blood count panel showed normal values. Respondent did not document an interpretation or reading of these test results.

H. On or about August 24, 1999, a blood test showed elevated cholesterol.

I. On or about August 27, 1999, a Pap smear was normal.

J. On or about September 13, 1999, a test for potassium was normal.

K. On or about February 15, 1999, a blood test showed normal cholesterol and triglyceride levels, but also H. Pylori and hepatitis antibodies.

L. On or about February 16, 1999, an ultrasound showed wall thickening of the bladder.

M. For the period September through December 1999, respondent had S.B. undergo multiple sessions of physical therapy. Respondent did not document any reason(s) for ordering the physical therapy, nor the results thereof.

N. On or about June 12, 2000, a blood test showed elevated cholesterol, triglycerides, BUN and magnesium. Respondent did not document an interpretation or reading of these test results.

O. On or about January 15, 2000, a laboratory test order sheet, used by respondent in the care of S.B., showed that every test available had been ordered, including a PSA for prostate cancer, which is applicable only to males. On this sheet, respondent noted anemia, coronary artery disease, hepatitis, hyperlipidemia, liver disease, arthritis, pancreatic disorder, hypothyroidism, myocardial infarction, osteoporosis, rheumatoid arthritis, systemic lupus erythematosus and venereal disease as diagnoses for S.B., though respondent's records for S.B. substantiated only a few of these conditions.

P. Respondent never documented having interpreted or read any of the abnormal laboratory test results, or of having advised S.B. about the abnormal test results, or of having formulated a plan for further evaluation and treatment of the abnormalities confirmed by test.

Q. Sometime in January, July and August 2000, respondent had S.B. undergo multiple sessions of physical therapy without documenting any medical necessity for this treatment or the results thereof.

R. On or about February 15, 2000, a Pap smear test of S.B. contained no endocervical cell component. Respondent did not document an order for repeat Pap smear testing.

S. On or about January 15, 2001, a Pap smear test of S.B. showed fungal organisms. Respondent did not document that S.B. was notified of this abnormal result on this date, or when seen on January 25, 2001.

T. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient S.B. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the

abnormalities briefly noted from physical examination; and/or failing to document same.

(3) By ordering a PSA test to detect prostate cancer for a female patient.

(4) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By indicating multiple diagnoses on a preprinted test order form without documented substantiation for said diagnoses.

(6) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(7) By engaging in a pattern of ordering diagnostic tests without medical indication.

(8) By failing to document reasons for ordering physical therapy, and failing to document the results thereof.

(9) By failing to follow-up on the abnormal mammogram result of March 1999 until one year had elapsed.

(10) By failing to document an awareness of the breast lesion abnormality, or that the lesion had been evaluated.

(11) By failing to timely order repeat Pap smear tests whenever the results were absent an endocervical cell component (e.g., test of February 15, 2000), which is essential for the early detection of cervical carcinoma; and/or failing to document same.

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FORTY-SIXTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

56. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 55 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient S.B. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities briefly noted from physical examination; and/or failing to document same.

(3) By ordering a PSA test to detect prostate cancer for a female patient.

(4) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By indicating multiple diagnoses on a preprinted test order form without documented substantiation for said diagnoses.

(6) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(7) By engaging in a pattern of ordering diagnostic tests without medical indication.

(8) By failing to document reasons for ordering physical therapy, and failing to document the results thereof

(9) By failing to follow-up on the abnormal mammogram result of March 1999 until one year had elapsed.

(10) By failing to document an awareness of the breast lesion abnormality, or that the lesion had been evaluated.

(11) By failing to timely order repeat Pap smear tests whenever the results were absent an endocervical cell component (e.g., test of February 15, 2000), which is essential for the early detection of cervical carcinoma; and/or failing to document same.

FORTY-SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

57. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 55 are incorporated by reference herein as if fully set forth.

FORTY-EIGHTH CAUSE FOR DISCIPLINE

(Excessive Testing)

58. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 55 are incorporated by reference herein as if fully set forth.

FORTY-NINTH CAUSE FOR DISCIPLINE

(Inadequate Records)

59. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 55 are incorporated by reference herein as if fully set forth.

FIFTIETH CAUSE FOR DISCIPLINE

(Gross Negligence)

60. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. On or about July 24, 1999, Patient A.S. [initials to protect privacy], a female, presented to respondent with complaints of low back pain, urinary tract discomfort and cervical pain. A blood pressure of 150/100 was recorded. Respondent briefly noted abnormalities in the neck area without delineation, description or explanation. CT scans of the cervical and lumbar areas were ordered, but the results were not documented or interpreted by respondent.

B. On or about January 31, 2000, respondent recorded a blood pressure of 165/100 for A.S. Abdominal, lung and musculoskeletal problems were briefly noted without delineation, description or explanation. Testing revealed Hepatitis A and H. Pylori antibodies, C reactive protein, anemia, and elevated cholesterol and triglycerides. Lopid 400 mg. x2 was prescribed for the cholesterol and triglyceride problems.

C. On or about February 29, 2000, A.S. presented with a complaint of low back pain. Blood pressure was recorded as 160/80. Respondent briefly noted abnormalities of the cardiovascular, pulmonary and musculoskeletal systems without delineation, description or explanation. Respondent did not document the treatment provided.

D. On or about April 25, 2000, A.S. returned to respondent with retro sternal and pressure type chest pain. Her blood pressure and heart rate were 170/100 and 120 beats per minute, respectively. Respondent referred A.S. to the hospital for

uncontrolled hypertension and chest pain. Following admission, A.S. underwent an adenosine thallium stress test which was normal. A.S. was discharged with Tenormin 50 mg. x2, Lotensin 20 mg. x2 and Ecotrin 325 mg.

E. On or about May 30, 2000, A.S. was seen by respondent for a rash. Her blood pressure was 160/100. The rash was treated with Atarax and hydrocortisone cream.

F. On or about June 1, 2000, respondent treated A.S. for hypertension, allergic reaction and depression. Her blood pressure remained elevated. A rectal abnormality was briefly noted without delineation, description or explanation. Repeat blood testing showed an improvement in cholesterol and triglyceride levels.

G. On or about June 15, 2000, A.S. presented with depression, osteoarthritis and hypertension. Her blood pressure was 140/100. An abnormality shown by rectal exam was again noted but without any delineation, description or explanation. Pulmonary function, bone density, and Pap smear tests were done. The bone density study revealed osteoporosis. The pulmonary function tests showed restrictive airway disease. No interpretations or readings of these tests results by respondent or another physician were documented.

H. From July 5 to August 7, 2000, A.S. underwent six (6) sessions of physical therapy for pain radiating from the lower back to the left knee. Respondent did not document an order for physical therapy, nor the results thereof.

I. On or about August 17, 2000, A.S. presented with urinary tract discomfort. Her blood pressure was 150/100. Vaginitis was noted, but the treatment provided, if any, was not documented.

J. On or about August 22, 2000, A.S. underwent a mammogram, which revealed a cyst or fibroadenoma in the right breast. A breast ultrasound was recommended. Respondent did not document an interpretation or reading of this mammogram result, nor a plan for evaluation and therapy (i.e., follow-up sonogram) to address it.

K. On or about October 9, 2000, A.S. was seen by respondent. Her blood pressure remained elevated. An abnormality of the external genitalia was briefly noted without delineation, description or explanation. A breast ultrasound was ordered.

L. On or about November 20, 2000, respondent briefly noted abnormalities with A.S.'s ears, eyes, nose, throat, heart and lungs, but without delineating, describing or explaining them.

M. On or about December 26, 2000, respondent ordered all available diagnostic laboratory tests, including a PSA, by using a test order sheet which listed diagnoses of anemia, coronary artery disease, hepatitis, hyperlipidemia, liver disease, osteoarthritis, pancreatic disorders, hypertension, hypothyroidism, osteoporosis, rheumatoid arthritis, systemic lupus erythematosus and venereal disease, even though respondent's records for A.S. failed to substantiate most of these conditions. Blood testing showed markedly elevated cholesterol (i.e., 277) and triglycerides (i.e., 561). H. Pylori antibodies were also found.

N. On or about January 18, 2001, A.S. presented to respondent, who recorded a blood pressure of 130/90.

O. On or about June 1, 2001, respondent recorded a blood pressure of 150/90 for A.S. An EKG was borderline abnormal with a sinus tachycardia, possible left atrial abnormality and nonspecific ST changes. A bone density study showed osteopenia/osteoporosis. Respondent did not document interpretations or readings of these test results by her or another physician.

P. On or about June 26, 2001, A.S. was seen by respondent for wrist pain.

Q. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patient A.S. as follows:

(1) By failing to assure that a follow-up sonogram of the right breast was timely performed after the mammogram result of August 22, 2000 revealed an abnormality; and/or failed

to document same.

(2) By failing to document the reason(s) for physical therapy or the results thereof.

(3) By ordering a PSA screen for prostate cancer for a female patient.

(4) By indicating multiple diagnoses on a pre-preprinted test order form without documented substantiation for said diagnoses.

(5) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(6) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(7) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(8) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(9) By engaging in a pattern of ordering diagnostic tests without medical indication.

FIFTY-FIRST CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

61. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of a patient constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraph 60 are incorporated by reference herein as if fully set forth.

B. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient A.S. as follows:

(1) By failing to assure that a follow-up sonogram of the right breast was timely performed after the mammogram result of August 22, 2000 revealed an abnormality.

(2) By failing to document the reason(s) for physical therapy or the results thereof.

(3) By ordering a PSA screen for prostate cancer for a female patient.

(4) By indicating multiple diagnoses on a pre-printed test order form without documented substantiation for said diagnoses.

(5) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(6) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(7) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(8) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(9) By engaging in a pattern of ordering diagnostic tests without medical indication.

FIFTY-SECOND CAUSE FOR DISCIPLINE

(Incompetence)

62. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent demonstrated a lack of medical knowledge and judgment in the care and treatment of a patient. The circumstances are as follows.

A. The facts, circumstances and opinions stated at above numbered paragraph 60 are incorporated by reference herein as if fully set forth.

FIFTY-THIRD CAUSE FOR DISCIPLINE

(Excessive Testing)

63. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 60 are incorporated by reference herein as if fully set forth.

FIFTY-FOURTH CAUSE FOR DISCIPLINE

(Inadequate Records)

64. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and accurate records of the care and treatment provided to a patient. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 60 are incorporated by reference herein as if fully set forth.

FIFTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

65. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that respondent engaged in acts and omissions in the care and treatment of multiple patients constituting an extreme departure from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraphs 11, 16, 21, 26, 31, 35, 40, 45, 50, 55 and 60, related to Patients T.D., Z.K., S.S.-M., M.G., S.Z., A.G., G.S., N.A., E.A., S.B. and A.S., respectively, are incorporated by reference herein as if fully set forth.

B. Respondent engaged in an extreme departure from the standard of practice in the care and treatment of Patients T.D., Z.K., S.S.-M., M.G., S.Z., A.G., G.S.,

N.A., E.A., S.B. and A.S. as follows:

(1) By engaging in a pattern of ordering diagnostic tests without medical indication.

(2) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(3) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(4) By ordering repeat tests or tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(5) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(6) By failing to adjust treatment in response to examination and laboratory findings, as in the cases of S.S.-M., S.Z., A.G., G.S., S.B. and A.S.; and/or failing to document same.

(7) By ordering physical therapy without documenting the medical necessity therefor, or the results thereof, as in the cases of G.S., E.A., S.B. and A.S.

(8) By ordering prostate cancer screening for female patients, as in the cases of N.A., E.A., S.B. and A.S.

FIFTY-SIXTH CAUSE FOR DISCIPLINE

(Repeat Negligent Acts)

66. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that respondent engaged in acts and omissions in the care and treatment of multiple patients constituting multiple departures from the standard of practice. The circumstances are as follows:

A. The facts and circumstances stated at above numbered paragraphs

11, 16, 21, 26, 31, 35, 40, 45, 50, 55 and 60, related to Patients T.D., Z.K., S.S.-M., M.G., S.Z., A.G., G.S., N.A., E.A., S.B. and A.S., respectively, are incorporated by reference herein as if fully set forth, and are supplemented by the following patient cases:

PATIENT L.S:

B. On or about March 17, 1999, Patient L.S. [initials to protect privacy], a male, was seen by respondent while hospitalized for spinal cord ependymona, erosive gastritis, erosive duodenitis and atypical chest pain.

C. On or about April 5, 1999, L.S. made his first visit to respondent's medical office for care and treatment. Respondent did not document a plan of treatment or medication regimen. Extensive laboratory panels were ordered, including a complete blood count, anemia profile, cardiac profile, thyroid profile, regional profile, arthritis profile, hepatitis profile, general chemistry and serology. The results included low hemotocrit, low platelet count, elevated cholesterol, H. Pylori and hepatitis antibodies. Respondent did not document an interpretation or reading of these results.

D. On or about March 27 and May 6, 1999, L.S. visited respondent for care and treatment. Respondent briefly noted multiple problems from physical examination, but did not delineate, describe or explain them. Respondent did not document an assessment or plan of treatment. Respondent did not document L.S.'s medications.

E. On or about May 17, 1999, L.S. returned to respondent, who made minimal notations of problems and findings following a physical examination.

F. On or about August 31, 2000, respondent ordered a repeat of the extensive laboratory panels performed on April 5, 1999. Respondent did not document the reason(s) for ordering all of the tests.

G. On or about September 29, 1999, respondent admitted L.S. to the hospital for neurogenic bladder and bowel, depression, hypertension, abdominal pain, urinary tract infection, constipation, and cervical spine tumor by history. An MRI scan showed a possible enhancing tumor at the C-6 level. Radiation therapy was

recommended. L.S. was discharged on October 5, 1999.

H. On or about November 1, 1999, L.S. returned to respondent's clinic for examination. The progress note for this date is blank, except for vital signs and a chief complaint.

I. On or about June 20, 2000, L.S. was hospitalized for neck pain radiating down the left arm and left-sided weakness. L.S. was discharged with diagnoses of cervical ependymona with no recurrence, thrombocytopenia, iron deficiency anemia, and chronic pain syndrome.

J. On or about June 27, 2000, L.S. returned to respondent, who noted abnormalities without delineation, description or explanation. Respondent did not document a plan for further evaluation or treatment.

K. On or about May 11, 2001, respondent ordered laboratory tests for L.S., including a complete blood count, complete metabolic panel, lipid panel, acute hepatitis studies, and serology for H. Pylori. The results included anemia, low platelet count, elevated blood sugar and cholesterol, H. Pylori and hepatitis antibodies. Respondent did not document an interpretation or reading of these results, nor a plan for further evaluation and treatment.

L. Respondent engaged in multiple departures from the standard of practice in the care and treatment of Patient L.S. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By ordering repeat tests and tests by panel without adequately documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by documented interpretation or

reading the abnormalities shown by test result.

PATIENT E.C:

M. Prior to September 11, 2000, Patient E.C. [initials to protect privacy], a female, was seen by respondent while she was hospitalized for lung cancer, anemia, depression and altered mental state.

N. On or about September 11, 2000, E.C. presented to respondent for follow-up examination. Respondent noted that E.C. had completed chemotherapy, but had chronic obstructive pulmonary disease. Respondent briefly noted abnormalities with the musculoskeletal system without delineation, description or explanation. A complete blood count panel was ordered, which showed anemia with a mild decrease in platelets. Respondent did not document a plan to address the anemia.

O. Respondent departed from the standard of practice in the care and treatment of Patient E.C. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

PATIENT M.H:

P. On or about August 25, 2000, Patient M.H. [initials to protect privacy], a female, presented to respondent for care and treatment. Respondent diagnosed hypertension, multiple sclerosis, pedal edema and CHF. Respondent's plan was to have M.H. hospitalized. After M.H. was admitted to the hospital, x-rays showed an absence of cardiac or pulmonary diseases.

Q. On or about September 8, 2000, M.H. returned to respondent, who noted the same abnormalities as before. Respondent also briefly noted abnormalities with the lungs and rectum, but without delineating, describing or explaining them. Vasospect and pulmonary function tests were ordered. The vasospect test showed an abnormal

venous pattern in the left leg, but no interpretation or reading of this result by respondent or another physician was documented. The pulmonary function tests showed "moderate obstruction as well as low vital capacity, possibly from a concomitant restriction," but no interpretation or reading of this result by respondent or another physician was documented.

R. Respondent also ordered a blood panel which showed elevated folic, B-12, cholesterol, triglyceride, sedimentation rate, and uric acid levels. Elevated SGOT and SGPT levels revealed a liver abnormality. An interpretation or reading of these results by respondent was not documented.

S. Respondent also ordered a Pap smear test, which contained no endocervical cell component. Respondent did not document ordering a repeat Pap smear.

T. Respondent departed from the standard of practice in the care and treatment of Patient M.H. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities briefly noted from physical examination; and/or failing to document same.

(3) By ordering pulmonary function and vasospect tests without adequately documenting the reason(s) or medical indication(s) therefor.

(4) By failing to address by documented interpretation or reading the abnormalities shown by test result.

PATIENT K.B:

U. On or about June 30, 1998, Patient K.B. [initials to protect privacy], a female, was discharged from the hospital. The discharge summary diagnoses were paralytic ileus, dehydration and electrolyte imbalance.

V. On or about September 8, 1998, K.B. was admitted to the hospital

for cellulitis, dehydration and hyponatremia.

W. On or about October 1, 1998, K.B. presented to respondent with a complaint of low back pain. Respondent briefly noted abnormalities of the ears, nose, throat and musculoskeletal system without delineating, describing or explaining them. Respondent did not document an assessment or plan of treatment.

X. On or about November 3, 1998, K.B. presented to respondent with a complaint of rib cage pain. Respondent briefly noted abnormalities involving the abdominal, cardiovascular and musculoskeletal areas but without delineating, describing or explaining them. Respondent did not document an assessment or plan of treatment.

Y. On or about November 6, 1998, K.B. was hospitalized for hyponatremia, hypokalemia, systemic lupus erythematosus, hypertension and severe degenerative joint disease. K.B. was discharged from the hospital on November 9, 1998.

Z. On or about December 1, 1998, K.B. returned to respondent for a check-up. A blood pressure of 160/00 was ~~recorded.~~ Respondent briefly noted abnormalities of the head and musculoskeletal system, but without delineating, describing or explaining them. Laboratory tests showed a liver abnormality by virtue of elevated LDH and GGTP, and sodium deficiency. Respondent did not document an interpretation or reading of these test results, nor that K.B. was advised of them.

AA. On or about December 28, 1998, K.B. presented to respondent with a complaint of low back pain. Respondent briefly noted abnormalities with the abdomen, eyes and lungs, but without delineating, describing or explaining them.

BB. On or about December 30, 1998, K.B. received physical therapy for acute sciatica. Respondent did not document the apparent referral for physical therapy, nor the results thereof.

CC. On or about January 18, 1999, K.B. presented to respondent, who briefly noted problems with the ears, eyes, nose, throat, neck, thyroid, lungs, cardiovascular and musculoskeletal systems, without delineating, describing or explaining them. Respondent did not document an assessment or plan of treatment for

these problems.

DD. On or about January 28, 1999, K.B. received physical therapy for acute sciatica. Respondent did not document the apparent referral for physical therapy, nor the results thereof.

EE. On or about February 1, 1999, respondent noted that while K.B. continued to experience low back pain, her hypertension was under control.

FF. Respondent departed from the standard of practice in the care and treatment of Patient K.B. as follows:

(1) By failing to delineate, describe and explain the types of abnormalities found; and/or failing to document same.

(2) By failing to formulate a plan of treatment to address the abnormalities noted from physical examination; and/or failing to document same.

(3) By failing to address by documented interpretation or reading the abnormalities shown by test result.

(4) By failing to document the reason(s) for ordering physical therapy and the results thereof.

FIFTY-SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

67. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that respondent has demonstrated a lack of medical knowledge and judgment in the care and treatment of multiple patients. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 66 are incorporated by reference herein as if fully set forth.

FIFTY-EIGHTH CAUSE FOR DISCIPLINE

(Excessive Testing)

68. Respondent is subject to disciplinary action under section 725 of the Code, in that respondent engaged in repeated acts of clearly excessive use of diagnostic procedures in

the care and treatment of multiple patients. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 66 are incorporated by reference herein as if fully set forth.

FIFTY-NINTH CAUSE FOR DISCIPLINE

(Inadequate Records)

69. Respondent is subject to disciplinary action under section 2266 of the Code, in that respondent failed to maintain adequate and adequate records of the care and treatment provided to multiple patients. The circumstances are as follows:

A. The facts, circumstances and opinions stated at above numbered paragraph 66 are incorporated by reference herein as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number A 52602, issued to SONIA YACOBIAN;

2. Revoking, suspending or denying approval of SONIA YACOBIAN's authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering SONIA YACOBIAN to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: August 29, 2002

RON JOSEPH
Executive Director
Medical Board of California
State of California
Complainant

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